



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

JAY C PROCTOR MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-2770-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

April 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting that his claim referenced above be reconsidered due to submission error."

Amount in Dispute: \$115.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "BEAUMONT FAMILY PRACTICE provided services to the claimant on the date above ...

One year from disputed date 11/7/13 is 11/7/14. The TDI/DWC date stamp lists the received date as 4/28/15 on the requestor's DWC-60 packet, a date greater than one year from 11/7/13. The requestor has waived its right to DWC MDR."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 07, 2013	CPT Code 99213 and 99080	\$115.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-38 – Services not provided or authorized by designated (Network/primary care) Provider

- 727 – Provider not approved to treat Texas Star network claimant. For network information call 800-381-8067
- A01 – Rule 129.5 indicates DWC 73 must be billed and filed by the doctor
- CAC-W1 – Workers Compensation State Fee Schedule adjustment
- CAC-38 – Services not provided or authorized by designated (Network/primary care) Providers
- 727 – Provider not approved to treat Texas Star Network claimant. For Network information call 800-381-8067

Issues

1. Is the requestor entitled to reimbursement?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The Texas Department of Insurance (“TDI”) rules at 28 Texas Administrative Code sections 10.120 through 10.122 address the submission of a complaint by a health care provider, to a workers’ compensation health care network (“network”). If the health care provider is dissatisfied with the resolution of such complaint, then it may submit a complaint to TDI. The Requestor in this dispute did not document the filing of such a complaint, or any finding by either the network or TDI as a result of a complaint, that the network had authorized any referral to the requestor for the services provided in this dispute.

Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. This dispute may **not** be resolved pursuant to 28 Texas Administrative Code §133.307; for that reason, no additional reimbursement can be recommended

2. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is November 07, 2013. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 28, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division’s MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	6/8/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.